INCIDENT, ACCIDENT, ILLNESS, DEATH OR FIRE REPORT

Michigan Department of Health and Human Services
Division of Child Welfare Licensing

INSTRUCTIONS

- **The completion of this form may optionally be used to document the requirements of the following licensing rules:**

  Child Placing Agencies R 400.12415 (2)

  Child Caring Institutions R 400.4167(1)(2)
  Court Operated Facilities R 400.10159(2)

- **The completion and submission of this form to the department is required by the following licensing rules:**

  Children's and Adult Foster Care Camps R 400.11127 (6)

FACILITY:

LICENSING CONSULTANT:

License Number	Facility/Home/Provider Phone Number ( )	FACILITY TYPE: ☐ Child Caring Institution ☐ Juvenile Detention	Licensing Consultant Name
Facility Name			
Address (Street Number and Name)	County		
City	State / Zip Code		

PERSON(S) IN CARE INVOLVED:

Name		Name	
Age	Sex ☐ M ☐ F	Age	Sex ☐ M ☐ F
Home Address If Other Than Facility/Home Address (Street Number & Name)		Home Address If Other Than Facility/Home Address (Street Number & Name)	
City	State / Zip Code	City	State / Zip Code
Home Phone Number If Other Than Facility/Home ( )		Home Phone Number If Other Than Facility/Home ( )	
Name of Parent (if minor)	Work Phone Number ( )	Name of Parent (If Minor)	Work Phone Number ( )

OTHER PERSON(S) INVOLVED / WITNESS(ES):

Name	Name
Address (Street Number and Name)	Address (Street Number and Name)
Phone Number ( )	Phone Number ( )

DISTRIBUTION:
Send original to your licensing consultant and retain a copy for your records.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	AUTHORITY: 1973 PA 116 COMPLETION: Voluntary/Mandatory PENALTY: May be in violation of licensing rule.

PERSON(S) NOTIFIED:

Name of Person Notified	Notification Date	Notification Time	Non-Applicable
Physician		☐ A.M. ☐ P.M. :	☐
Referring/Responsible Agency **(Child Caring Institution Only)**		☐ A.M. ☐ P.M. :	☐
Probate Court **(Juvenile Detention Only)**		☐ A.M. ☐ P.M. :	☐
Law Enforcement Agency		☐ A.M. ☐ P.M. :	☐
Fire Marshal		☐ A.M. ☐ P.M. :	☐
Local Coroner		☐ A.M. ☐ P.M. :	☐
Family Member		☐ A.M. ☐ P.M. :	☐
Other (Specify)		☐ A.M. ☐ P.M. :	☐

Incident, Accident, Illness, Death or Fire		
Date:	Time: ☐ A.M. ☐ P.M.	Location:
Description, Cause, Surrounding Circumstances		

	N/A
If Fire, State Extent of Damage	☐
First Aid Given and When, if Applicable	☐
Who Provided First Aid, if Applicable	☐
Other Action Taken	
Physician's Diagnosis of Injury or Illness, if Applicable	☐
Name of Treating Physician, Medical Facility, Hospital, if Applicable	☐
Phone Number of Treating Physician, Medical Facility, Hospital, if Applicable	☐
Cause of Death, if Applicable / Was an Autopsy Performed ☐ Yes ☐ No	☐

Were Any Handicaps, Health Problems, or Exceptions Listed on the Child's Health Records?

☐ Yes ☐ No

Signature of Person Completing This Report	Title	Date
Signature of Licensee/Responsible Person	Title	Date